PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, June 26, 2001, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Chairman Howard K. Koh, M.D., MPH (Chairman), Ms. Phyllis Cudmore, Mr. Manthala George Jr., Mr. Benjamin Rubin, Mr. Albert Sherman, Ms. Janet Slemenda and Dr. Thomas Sterne; Ms. Shane Kearney Masaschi absent; one vacancy. Also in attendance was Attorney Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Mr. Phillip McCauley, Deputy Director, Hospital Bureau, Dr. Paul Dreyer, Director, Division of Health Care Quality; Ms. Brunilda Torres, Director, Office of Minority Health, Mr. Arthur Friedman, Consultant, Bureau of Substance Abuse; Ms. Joyce James, Director, and Mr. Jere Page, Senior Analyst, Determination of Need Program; and Deputy General Counsels Steve Chilian, Edmund Sullivan and Carl Rosenfield, Office of the General Counsel.

RECORDS OF THE PUBLIC HEALTH COUNCIL:

Records of the Public Health Council Meeting of February 27, 2001 were presented to the Council for approval. After consideration, upon motion made and duly seconded, it was voted (unanimously): That records of the meeting of February 27, 2001 be approved.

REQUEST FOR APPROVAL OF THE GOVERNING BODY BYLAWS FOR THE PUBLIC HEALTH HOSPITALS:

The Governing Body ByLaws for the Public Health Hospitals were presented to the Council for approval. After consideration, upon motion made and duly seconded, it was voted (unanimously): That the Governing ByLaws for the Public Health Hospitals be approved.

PERSONNEL ACTIONS:

In a letter dated June 13, 2001, Katherine Domoto, M.D., MBA, Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of appointments and reappointments to the medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewsbury Hospital, under the authority of the Massachusetts

General Laws, Chapter 17, Section 6, the appointments and reappointments to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning June 1, 2001 to June 1, 2003.

APPOINTMENTS:	**STATUS/SPECIALITY:**	**MED. LIC. NO.:**
Shahla Asvadi, MD	Provisional Consultant Dermatology	52195
Theodore Lindauer, MD	Provisional Active Psychiatry	28328
Bruce Turner, MD	Provisional Affiliate Psychiatry	206303
Jeannie Wei, MD	Internal Medicine/Cardiology	46192

REAPPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LIC. NO.:**
Nicholas Casaburi, MD	Active	28122
Khatija Gaffar, MD	Active	53316
Syed Rahman, MD	Active	73277
Jeffrey Simmons, MD	Consultant	39537
Guillermo Walters, MD	Consultant	74668

In a letter dated June 11, 2001, Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of reappointments to the medical and allied health staffs of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the reappointments to the medical and allied health staffs of Lemuel Shattuck Hospital be approved as follows:

PHYSICIAN REAPPOINTMENT:	**STATUS/SPECIALTY:**	**MED. LIC. NO.:**
Frank Davidson, MD	Pulmonary/Active	333520

ALLIED HEALTH PROFESSIONAL RE-APPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LIC. NO.:**
Carol Bowen, RNCS	Allied Health Professional	130826
Phyllis Bluhm, PA-C	Allied Health Professional	869284
Marjorie Goodwin, RNCS	Allied Health Professional	114364
Linda Manjarrez, EdE/RN,CS	Allied Health Professional	153220

In a memorandum dated May 23, 2001, Howard K. Koh, Commissioner, Department of Public Health, Boston, recommended approval of an appointment of Richard Newhall to Program Manager VI (Director of Personnel). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Richard Newhall to Program Manager VI (Director of Personnel), be approved.

In a memorandum dated May 23, 2001, Howard K. Koh, Commissioner, Department of Public Health, Boston, recommended approval of an appointment of James T. Murphy to Administrator VI (Director, HIV/AIDS Surveillance) AIDS Bureau. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of James T. Murphy to Administrator VI (Director, HIV/AIDS Surveillance) AIDS Bureau be approved.

In a letter dated May 23, 2001, Howard K. Koh, Commissioner, Department of Public Health, Boston, recommended approval of an appointment of Debra A. Tosti to Administrator VIII (Chief Operating Officer) Tewksbury Hospital. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Debra A. Tosti to Administrator VIII (Chief Operating Officer) Tewksbury Hospital, be approved.

In a memorandum dated May 23, 2001, Howard K. Koh, Commissioner, Department of Public Health, Boston, recommended approval of an appointment of Mindy Mazur to Program Manager V (Regional Director, Metrowest Activity Initiative). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Mindy Mazur to Program Manager V (Regional Director, Metrowest Activity Initiative) be approved.

In a memorandum dated May 23, 2001, Howard K. Koh, Commissioner, Department of Public Health, Boston, recommended approval of an appointment of Paul J. Tierney to Administrator VI (Director of Food and Drug Program). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Paul J. Tierney to Administrator VI (Director of Food and Drug Program) be approved.

In a memorandum dated May 23, 2001, Howard K. Koh, Commissioner, Department of Public Health, Boston, recommended approval of an appointment of Jorge Sanchez to Program Manager V (Assistant Director of Policy and Planning). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Jorge Sanchez to Program Manager V (Assistant Director of Policy and Planning) be approved.

STAFF PRESENTATION:

"BEST PRACTICES FOR INTERPRETER SERVICES," by Brunilda Torres, Director, Office of Minority Health

Beginning July 1, 2001, hospitals throughout Massachusetts will be required to provide interpreter services in connection with all emergency room services provided to non-English speaking patients. "In a hospital emergency room, clear and fast communication can mean the difference between life and death," said Massachusetts Department of Public Health Commissioner Dr. Howard Koh. "This new law will ensure that accurate, complete and timely information is gathered in hospital emergency departments in order to provide the highest quality of care and treatment." The Massachusetts Department of Public Health unveiled its regulations for hospitals to follow in implementing the new law. The regulations were presented to the Public Health Council for a final vote of approval. The proposed final regulations would require the following:

- Hospital designation of a coordinator of interpreter services
- Posting of notices and signage informing emergency room patients of their right to interpreter services
- Hospitals to perform an annual language needs assessment in their service areas
- Assurance by hospitals that interpreters have received appropriate training
- Hospitals must refrain from encouraging the use of family members from interpreting and are prohibited from using minor children

The Massachusetts Department of Public Health has developed Best Practice Guidelines to assist all acute care hospitals in developing quality interpreter services. Massachusetts has long been on the forefront of the development and provision of Interpreter Services in clinical settings. Since 1989, most hospitals requiring permission from the Department of Public Health to transfer ownership or expand services have submitted plans for provision of interpreter services as part of the Determination of Need process. Through this process, over fifty hospitals have developed interpreter services, training for both medical interpreters

and medical providers and systems for tracking the language needs and interpreter requests of patients. In 1996, the Massachusetts Division of Medical Assistance established an Acute Hospital Request for Application process that developed quality measures for interpreter services. Through this quality improvement initiative, hospitals establish minimum standards of practice to ensure MassHealth members access to trained medical interpreters at all key points of contact throughout the hospital. On April 14, 2000, the Governor signed Chapter 66 of the Acts of 2000, "An act requiring competent interpreter services in the delivery of certain acute health care services which mandates that every acute care hospital shall provide competent interpreter services in connection with all emergency room services provided to every non-English speaking patient."

Dr. Dreyer, Director, Division of Health Care Quality, said in part, "…The law requires hospitals to provide competent interpreter services in connection with all emergency room services provided to every non-English speaker who is a patient or who seeks appropriate emergency care or treatment. The law gave the Department the ability to promulgate regulations, but it left it up to our discretion as to whether we thought regulations would be useful for several reasons, in particular because the law has general language about when hospitals should choose various kinds of modalities of interpreter services…So we developed regulations that included more specificity on that point. The draft regulations that we developed required hospitals to designate a Coordinator of Interpreter Services with overall responsibility for the program. The law requires the provision of signage informing persons coming to the ER of their rights to interpreter services. The law mandates that hospitals conduct an annual language needs assessment in their population in the community. Hospitals must ensure that interpreters have received appropriate training in the skills and ethics of interpreting. And there is a requirement that hospitals are prohibited from using minor children as interpreters. That is the standard of care. And there is also language that hospitals should not use family members…"

Ms. Brunilda Torres, Director, Office of Minority Health, said in part, "…Interpreter services improve healthcare delivery. They ensure the transmission of information between the medical provider and the patient that is appropriate to that situation. They improve the diagnostic capacity of the provider. They save healthcare dollars. They reduce litigation, and in fact, reduce medical errors…The best practices document identifies and describes the components of an optimal interpreter services program for a hospital…All that we are accumulating at this point will help, in fact, develop this essential ancillary service within hospital context that will help providers be able to communicate. The document is not prescriptive. There are multiple examples in terms of how to help patients self-identify their language, which is a critical element…It provides strategies to conduct an institutional assessment that really helps the institution identify the areas that need improvement, and we provided guidelines for the translation of the materials. We have also identified critical issues, such as staffing and cost, that need to be addressed when developing these services. We have developed training issues, competency assessment, and ethics of interpretation, all of which are really critical to developing quality services…"

State Representative Jarret T. Barrios, Cambridge, Massachusetts, said in part, "…I was one of many folks sponsoring this legislation…The problem is a lot of folks who come here, when their parents are in the emergency room, revert to the language they are most comfortable in. And that's something we understand…The language that folks are most comfortable in should be the language in an emergency room setting they are able to communicate with a physician. And that was the purpose of this law. When we passed the law last year, it was with after about 12 years of effort...Folks came together, people who have experience in the field, recognizing that our number one obligation is providing healthcare access.

And meaningful healthcare access to folks whose first language is not in English, oftentimes requires that we have some sort of interpreter services…Where we have 102 languages spoken in the Commonwealth, and 75 hospitals, and a number of other mental health facilities, it would clearly be impossible to have that. The burden or standard is up to the hospital to determine. The hospitals understand their patient population better than we ever will. And it will be their decision and the financial incentive, to have an interpreter there if they have a lot of folks who speak that language because it is cheaper. And where they are unable to have that, they have telephonic interpretation available to help people access remotely, telephonically, interpreter services for lower incidence languages in those communities. This is a law which was designed to work for the hospitals. The regulations are wonderful and I think they are going to work for hospitals. Finally, what we developed because of this law, because these regulations were going into effect, was a first of its kind program that is going to have a one-year academic curriculum with a one semester on-site training program at the Cambridge Health Alliance. We are going to be graduating people who have come from their native countries, who are fluent both in English and in their native language, and who now have real job opportunities as interpreters, who are going to be very capable to help the Commonwealth, and the hospitals in the Commonwealth, meet the new need for interpreters. This is a side benefit, really creating opportunities for immigrants in the Commonwealth and creating the opportunity for us to comply with this law. It has been a wonderful result, one which has brought immigrants into our public health system, in really helping the Commonwealth comply with that stated goal of improving healthcare access for everybody in the Commonwealth."

NO VOTE – INFORMATIONAL ONLY

Note: The regulation on interpreter services was heard along with the presentation.

REGULATION:

REQUEST FOR PROMULGATION OF REGULATIONS 105 CMR 130.000 REGARDING INTERPRETER SERVICES IN HOSPITAL EMERGENCY DEPARTMENTS:

Dr. Paul Dreyer, Director, Division of Health Care Quality, said in part, "We are here to request final promulgation of amendments to hospital licensure regulations governing the provision of interpreter services in hospital emergency departments. Draft regulations were presented for the Council's information at the Council's March meeting and a public hearing was held on May 14, 2001. Chapter 66 of the Acts of 2000, signed by the Governor on April 14, 2000, requires hospitals to '…provide competent interpreter services in connection with all emergency room services provided to every non-English speaker who is a patient or who seeks appropriate emergency care or treatment.' The law, which takes effect July 1, 2001, gave the Department the option of promulgating regulations in connection with implementation. The Department decided that regulations would be useful in clarifying certain features of the law (the choice to use paid staff interpreters versus a telephonic service), and in setting out processes for hospitals to follow in implementing the law. The draft regulations presented to the Council contained the following features:

- Hospitals must designate a coordinator of interpreter services with overall responsibility for the operation of the program

- Hospitals must provide notices and signage informing persons coming to the emergency department of their right to interpreter services.

- Hospitals must conduct an annual language needs assessment in their service areas

- Hospitals must assure that interpreters have received appropriate training in the skills and ethics of interpreting

- Hospitals must refrain from encouraging the use of family members from interpreting, and are prohibited from using minor children

Written or oral testimony was received from five individuals: Thomas Barker representing the Massachusetts Hospital Association, Dr. Gert Walter representing the Massachusetts College of Emergency Physicians, Robert Marra of Health Care for All, Ernest Windsor, of the Mass. Law Reform Institute, and Mary Lou Sudders, the Commissioner of the Department of Mental Health…In response to concerns expressed at the hearing, several points have been clarified, and the draft amendments have been modified, as follows:

- The proposed regulations do not mandate that the position of coordinator of interpreter services be full time; rather they require that hospitals designate a person who will have overall responsibility for the interpreter services program.

- The proposed regulations make clear that the Department will provide translations of signage informing patients of their right to interpreter services.

- The proposed regulations have been amended to clarify that the collection of information from family members is an acceptable practice.

- The proposed regulation has been changed to remove the requirement that hospitals refrain from suggesting that patients use family members as interpreters, but it retains the requirement that hospitals may not require or encourage the use of family members as interpreters.

- The regulations have been modified to include the requirement that hospitals make available a translated copy of the law upon request.

In response to Commissioner Sudder's comments, while it is true that the requirement for training that is 'culturally competent' is not explicitly contained in the statute, such training may be crucially important in communicating with persons from particular cultural backgrounds, and so the requirement has been retained in the regulation. Similarly, we have retained the requirement for the inclusion of primary language and self reported race/ethnicity in management information systems. This information is necessary for the needs assessment, and is consistent with the Division of Health Care Finance and Policy's proposal for an all payer emergency department data set, which would include demographic information similar to that already collected from hospital inpatients."

After consideration, upon motion made and duly seconded, it was voted unanimously to **approve the Request for Promulgation of Regulations 105 CMR 130.000 Regarding Interpreter Services in Hospital Emergency Departments**; that a copy of the approved regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,713**. A public hearing was held on May 14, 2001.

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PROPOSED REGULATION:

INFORMATIONAL BRIEFING ON REGULATIONS 105 CMR 168.000 WHICH SETS FORTH STANDARDS FOR LICENSURE OF ALCOHOL AND DRUG COUNSELORS:

Mr. Arthur Friedman, Consultant, Bureau of Substance Abuse, said in part, "M.G.L. c.111J which was enacted in the 2000 session with an effective date of July 1, 1999, set statutory requirements for the licensing of Alcohol and Drug Counselors and provided for two distinct levels of licensure, with an option to create additional categories as indicated. M.G.L.c.111J directed the Department of Public Health to establish the procedures for application, approval, exemption and relicensure and gave it overall authority to implement the licensure process. To most effectively develop these protocols and procedures, the Department convened an advisory group comprised of providers, advocates and consumer representatives. Over an eight month period, the advisory group met monthly and reviewed multiple drafts of the proposed regulations, incorporating relevant input and modifications as needed. An extensive national search of the standards set by other states, as well as comparative analysis of alcohol and drug counselor certification was conducted. The final draft has been approved by both the Department staff and the Advisory Group, and includes the following major sections:

1. **Definitions:** A comprehensive list of definitions that operationalize all the relevant terms is provided. For example, terms such as "approved work experience," "behavioral sciences, and "recognized certifying body" help to more specifically define the requirements for licensure in a range of critical areas.

2. **Exemptions:** This section refers to the individuals who are exempt from the licensing requirements based on discipline and work setting. It also identifies other qualified members of other professions who can practice alcohol or drug counseling without obtaining a license. A key point is that any employee of an alcohol or drug treatment program licensed by the Department is automatically exempt as he/she is covered under the facility's license.

3. **Eligibility Requirements:** These are the four categories of Alcohol and Drug Counselor proposed – Alcohol and Drug Manager, Alcohol and Drug Counselor I, Alcohol and Drug Counselor II, and Alcohol and Drug Counselor Assistant. The statutory requirements are incorporated for the two levels delineated in the law (Alcohol and Drug Counselor I and Alcohol and Drug Counselor II). The other two categories were added in an effort to be responsive to the diverse background and education of individuals who work in recovery-based services. For each category, age, work experience, education, practical experience, examination, ethical and/or continuing education requirements are described.

4. **Application:** This section details the requirements and guidelines to sit for the oral and written examinations including forms, documentation, signature, evaluation and fees. The process for the review of applications is also included.

5. **Examinations:** Guidelines for the administration of examinations is provided, including the procedures for examination review, notification and other administrative reviews.

6. **Term of Licensure:** This section explains the term of licensure and sets criteria for license renewal (i.e., continuing education, fees, filing).

7. **Special Credentialing:** Based on the Chapter 111J legislation, special credentialing refers to the process (and criteria) available for a one-year period by which applicants can be credentialed as Alcohol and Drug Counselors I and II without sitting for the examinations.

8. **Reciprocity and Continuing Professional Education:** These two sections refer to credentialing based on reciprocity and continuing professional education requirements and the "guidelines" the Department will issue for "all continuing professional education programs and providers, including the eligibility requirements for distance learning and education."

9. **Administrative and Legal Procedures:** A detailed description of administrative procedures pursuant to complaints, denial, suspension, adjudicatory proceedings, unauthorized practice and severability is included."

In conclusion Mr. Friedman stated, "We will proceed to public hearing on the proposed regulations of 105 CMR 168.000. We believe that the proposed regulations will provide alcohol and drug counselors the opportunity to obtain a credential based on their specialized experience and expertise that will improve the quality of these services throughout the Commonwealth."

NO VOTE – INFORMATIONAL ONLY

DETERMINATION OF NEED:

CATEGORY 2:

PROJECT APPLICATION NO. 6-3986 OF SALEM HOSPITAL D/B/A NORTH SHORE CANCER CENTER – ACQUISITION OF A 6-10 MEV LINEAR ACCELERATOR AND ASSOCIATED NEW CONSTRUCTION AND RENOVATION COSTS TO LOCATE THE UNIT AT THE EXISTING NORTH SHORE CANCER CENTER IN PEABODY:

Mr. Jere Page, Senior Analyst, Determination of Need Program, said in part, "The applicant is Salem Hospital d/b/a the North Shore Cancer Center. They are here today to seek approval of the third linear accelerator of their Center's existing location in Peabody. We are recommending approval of this particular third unit based on current operating capacity of the Center of 140 percent, which significantly exceeds the 90 percent capacity standard required by the DoN Radiation Therapy Guidelines. The recommended maximum capital expenditure is $2.4 million. These are in August 2000 dollars, when the

application was filed. A public hearing was held on January 9th at the request of the Janel Woodhouse Ten Taxpayer Group. The testimony presented at the hearing, and in some subsequent written comments by members of the taxpayer group expressed concern regarding a possible adverse impact of the proposed additional unit on patient volume at the Northeast Radiation Oncology Department, a cancer treatment center, which is located in Peabody within a mile of the applicant's facility, and is managed by a partnership of Lahey Clinic, Northeast Tel Systems and Union Hospital. The taxpayer notes that the applicant, i.e., the North Shore Cancer Center, and Union Hospital, are subsidiaries of the North Shore Medical Center, and that given the applicant's current high operating capacity, the taxpayer group questioned why some of the applicant's excess volume is not being referred to the Northeast Regional facility rather than retained at the applicant's facility. The taxpayer's concern, because of this, that approval of a third unit at the applicant's facility may result in potential loss of patient volume at the Northeast Regional Radiation Oncology facility, which also provides radiation therapy services and is located in close proximity to NSCC in Peabody. The taxpayer asserts that NSCC should have accessed the operational capabilities and capacities of other radiation therapy providers in the area, such as Northeast Regional, before deciding to add the additional unit. In responding to these concerns, the staff notes that the applicant has submitted documentation indicating that in October 1998, the applicant attempted to enter into an arrangement with Northeast Regional that would have allowed Northeast Regional to share some of the applicant's excess volume. However, the applicant reports that this attempt was unsuccessful because the treatment times offered to the applicant's patients by Northeast Regional were inconvenient and the requested cost for treatment was excessive. The applicant further reports that after this attempt to collaborate and this patient volume continued unabated, it decided to seek an approval of a third unit to accommodate its growing patient volume. In conclusion, after consideration of these issues, the staff continues to recommend approval of this project with conditions…"

After consideration, upon motion made and duly seconded, it was voted: Chairman Howard Koh, M.D., Ms. Phyllis Cudmore, Mr. Manthala George Jr., Mr. Benjamin Rubin, Mr. Albert Sherman and Ms. Janet Slemenda in favor; Dr. Sterne recused, **to approve Project Application No. 6-3986 of Salem Hospital d/b/a North Shore Cancer Center,** (summary of which is attached to and made a part of this record as **Exhibit Number 14,714),** based on staff findings, with a maximum capital expenditure of $2,400,000 August 2000 dollars and first year incremental operating costs of $903,102 (August 2000 dollars). As approved, the application provides for expansion of existing radiation therapy service through acquisition of a third dual energy (6-10 MeV) linear accelerator and related accessories, as well as new construction and renovation to accommodate the new unit. The additional unit will be located at the existing North Shore Cancer Center at 17 Centennial Park in Peabody. This Determination is subject to the following conditions:

1) The North Shore Cancer Center shall accept the maximum capital expenditure of $2,400,000 (August 2000 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 752.

2) The North Shore Cancer Center shall contribute 100% in equity ($2,400,000 in August 2000 dollars) to the final approved maximum capital expenditure.

3) For Massachusetts residents, North Shore Cancer Center shall not consider ability to pay or insurance status in selecting or scheduling patients for radiation therapy services.

4) Within one year of implementation of the new third unit, North Shore Cancer Center shall seek accreditation in radiation oncology by the American College of Radiology.

5) Prior to initiation of the service, North Shore Cancer Center shall submit evidence of compliance with all applicable standards of safety and operation imposed by law, including an updated certificate of accelerator registration from the Department's Radiation Control Program for the two existing units, as well as the proposed third unit.

6) North Shore Cancer Center shall not begin construction until it has received written, final approval of its plans from the Department's Division of Health Care Quality.

7) The North Shore Cancer Center shall provide $24,000 per year for a total of $120,000 (August 2000 dollars) over a five-year period to fund community health programs in the North Shore Community Health Network Area (CHNA) 14. These programs will be used by NSCC's parent, the North Shore Medical Center to add to its current minority outreach efforts by adding a series of oncology screening, prevention and outreach programs directed to Southeast Asian and Hispanic people. These programs will be informed and developed by a series of focus groups and involve other survey processes, including Enlace and the NSCHN Asian Health Initiative. Funding for this initiative will begin upon project implementation and notification to the Department's Office of Healthy Communities.

8) North Shore Cancer Center shall agree to operate radiation therapy equipment which has pre-market Approval by the Food and Drug Administration.

Note: The applicant was present but did not wish to speak.

The meeting adjourned at 10:05 a.m.

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Howard K. Koh, M.D., MPH
Chairman, PHC

LMH/SB